January 13, 2006

Washington State PEBB and Health Savings Accounts

Washington State Health Care Authority

MERCER
Health & Benefits

MMC Marsh & McLennan Companies

Contents

1

Executive Summary

Healthcare consumerism, Health Savings Accounts, and other account-based health plans are concepts being evaluated and adopted by plan sponsors to:

- Control cost and utilization
- Promote transparency
- Support care management
- Increase member involvement in health decisions
- Improve the value and quality of care.

HSAs are the most recent in this series of benefit designs. Governed by a number of federal mandates, at their most basic level these individual-owned, tax-advantaged healthcare financial accounts are similar to an IRA or 401(k).

Though adoption has been brisk by healthcare standards, those expecting the entire country would be using these plans in a short time have not seen that come to pass – significant change in the monolithic and entrenched healthcare landscape happens incrementally. Notably, according to Mercer's 2005 National Survey of Employer-Sponsored Health Plans, the largest and most sophisticated healthcare purchasers have been leading the way: 22% had an account-based plan in place for 2005 and 29% expect to in 2006. To meet this demand, health plan vendors and financial services companies have been furiously partnering and building solutions to capture market share.

Long-term implications of HSAs are unclear – with considerable opportunity for unintended negative consequences. These plans must be specifically designed, monitored, and refined to overcome concerns such as:

- Barriers to appropriate preventive care
- Risk segmentation and adverse selection
- Equity for the chronically ill and lower paid.

Despite potential issues, preliminary evidence is good. It shows HSAs generally are having the desired impact – and can do so without reducing proper care, destabilizing traditional plans, or creating undue financial risk/hardship for special-needs populations.

Deciding whether to introduce HSAs into the PEBB benefit environment requires careful analysis, and adoption would likely be a gradual process. Based on initial assumptions and high-level financial modeling, we anticipate:

- The cost implications of offering an HSA option could range from savings of $3 million (0.3% of total cost) at 2% enrollment to $20 million (1.8% of total cost) at 10% enrollment (low enrollment is likely in the early years without significant changes to existing programs)
- Additional benefits beyond positive cost implications, such as providing a meaningful new choice to early retirees and creating a vehicle for active workers to start saving for healthcare in retirement.

This decision would carry a host of considerations, including:

- A sound, capable vendor partner to deliver the HSA
- Communication and education sponsored by the vendor partner and supported by the State
- Adequate, usable tools and resources for members
- A strong base of information on provider services and treatment options as the foundation for a successful consumerism initiative.

If introduced thoughtfully and managed well, HSAs can help improve healthcare choice, value, and transparency while controlling cost in the PEBB benefit environment.

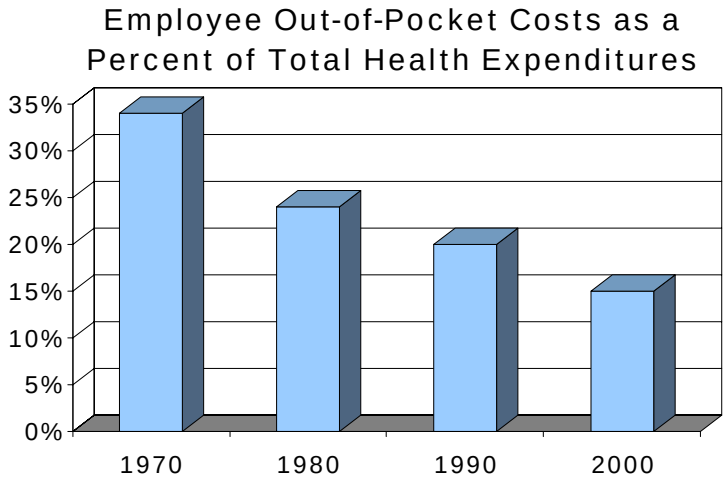
2

History of HSAs

As relatively recent additions, HSAs are a logical next step in the long path of plan sponsor efforts to:

- Encourage member consumerism
- Restore reasonable levels of individual financial accountability
- Reduce the rate of increase in benefit expenditures.

Individual responsibility for healthcare purchasing decisions has declined dramatically in the past 3 decades. As this chart indicates, employees paid a significantly higher portion of their healthcare expenses in 1970 than they do today.



(Source: EBRI Brief #247 - July 2002)

Attempts to increase consumer choice, cost awareness, and accountability in healthcare have a long history and many manifestations, including:

- Coinsurance – Members pay part of the cost for services
- Schedule plans – Members are responsible for provider charges above a maximum set fee for each service
- Cafeteria plans –Members receive dollars/credits to use for various benefits
- Specialist copays – Members pay more for care from a specialist physician than a primary care physician
- Multi-tier prescription drug programs – Members' cost share depends on the drug's cost category, which could be based on patent status, total cost, or necessity
- Flexible Spending Accounts – Members can set aside a tax-free amount to pay for otherwise unreimbursed medical expenses (FSA funds do not roll over and are forfeit if not used during the year).

While each of these strategies can sensitize consumers, they are not enough for real, ongoing cost and quality transparency. They don't supply accurate, understandable data about cost and quality of care or effectively encourage members to behave like financially responsible consumers.

Healthcare consumerism is inextricably tied to transparency in cost and quality.

But account-based plans motivate an active interest in the cost and quality of professionals, medications, and treatments. Supported by reliable, clear information, these plans can get members engaged in their health and related expenses. *HSAs are an important element in the equation* – adding the personalized financial vehicle that enables members to plan and pay for the care they need and want.

Milestones

- The conceptual foundation for HSAs was laid in 1996, with the enactment of HIPAA, which introduced the Archer Medical Savings Account. MSAs allowed individuals to establish and contribute to a tax-preferred account, like an IRA designated for health expenses. Funds in the MSA rolled over from year to year, earned interest, and were individually owned.
- MSAs, however, were impeded by restrictions and never reached their full potential. An important limit was the MSA "sunset" date – their legality was to expire automatically without Congressional action. Also, MSAs were allowed only for small companies, required unattractive benefit designs, and were restricted in the number that could be set up. Given these drawbacks, vendors hesitated to invest in product development and marketing. Without competitive offerings available, few employers adopted an MSA.

- Nevertheless, business and insurance experts believed such accounts could improve the dynamics of healthcare and sought ways to bypass the MSA's legislated limits. Innovative companies interpreted the IRS code to allow a tax-advantaged account. Unlike MSAs, which were controlled by individuals, the new account was a benefit tool controlled by plan sponsors. With names like Personal Care Account and HealthFund, the new generation of health-focused accounts was adopted by a few leading-edge companies starting in 2000.

- In 2002, IRS Revenue Ruling 2002-41 and Notice 2002-45 identified this latest iteration as Health Reimbursement Arrangements. The HRA removed significant barriers to the emerging market for account-based health plans (which also came to be called CDHPs, for consumer-directed or consumer-driven health plans; see the next page). Businesses began to adopt HRAs and the number of vendors grew. Despite this market interest, HRAs remained a very small percentage of health benefits provided nationally.

- The Medicare Modernization Act enabled the Health Savings Account in December 2003. Less restrictive than MSAs, HSAs could be offered by employers of any size, were permanent unless Congress acted to eliminate them, and had no limit on how many could be adopted. Unlike the HRA, which was a benefit tool controlled by the plan sponsor, the HSA was a financial tool controlled by the member. While there were still benefit design rules, they were more flexible.

- With less than a month between HSAs being legislated and becoming enabled on January 1, 2004, vendors had scrambled to meet what they expected would be significant demand. Some small HSAs were established between January and May in 2004; the first employer with more than 1,000 employees offered an HSA in June 2004.

- Throughout most of 2004, marketplace uncertainty surrounded HSA rules and requirements. Employers were hesitant to adopt HSAs – partly because compliance questions were unanswered and partly because the products were untested. The Treasury, IRS, and Department of Labor issued volumes of practical guidance on HSA compliance throughout 2004 and early 2005. Despite this significant effort to create a safe regulatory environment, by the time the bulk of this guidance was delivered (IRS Notice 2004-50, released July 23, 2004, had 88 Q&As), most large employers had already finalized their benefits for 2005.

- While January 2005 saw modest adoption of HSAs, the vendor marketplace continued to invest in enhancing products, expecting substantial demand forthcoming. Most plan sponsors were asking about HSA solutions in their renewal discussions and bids.

- At the same time, state governments were hard at work eliminating barriers – several had benefit coverage laws that would prevent an HSA-compatible health plan and nearly a dozen had tax codes that didn't conform to the federal tax-free status of HSAs. Numerous state laws have been passed to overcome the design and taxation barriers[1], yet uniform treatment of HSAs does not yet exist, and at least 6 states still do not comply with federal HSA tax rules (AL, CA, MA, ME, NJ, and WI).

CDHP Details

CDHPs, in general, are PPO plans with a high deductible and these characteristics:

- Motivate members to be active participants in healthcare decisions through financial incentives
- Include an HSA or HRA
- Provide information and tools to support member decisions on healthcare
- Have prescription drug and office visit deductibles (per family, not per individual) and coinsurance.

Because of the accounts' multi-year, rollover nature, these plans must be viewed over time to appreciate their implications and results – 1-year comparisons to other plans are deceptive.

* * * * *

In summary, HSAs/HRAs in a CDHP would seem to offer PEBB and members potential advantages over time.

3

How HSAs Work

As financial accounts for healthcare that are owned by an individual, HSAs have these features:

- Contributions can be made by a plan sponsor, a member, or both
- The contributions are tax-free, earn interest, and can be invested tax-free
- If the money is spent on IRS-defined qualified medical expenses, distributions also are tax-free (federally and in most states)
- The money in an HSA rolls over year to year and is portable between jobs as well as into retirement
- To be eligible for establishing and contributing to an HSA (but not for spending HSA funds already accumulated), an individual must be enrolled in a federally-defined, HSA-compatible High Deductible Health Plan (HDHP).

The HSA contribution maximums listed below are indexed annually to the CPI.

Maximum HSA contributions and HDHP design criteria for 2006 are described in the following table.

	Single		Family	
	In Network	**Out of Network**	**In Network**	**Out of Network**
Minimum Deductible	$1,050	$1,050	$2,100	$2,100
Maximum Deductible	$5,250	None	$10,500	None
Minimum Out of Pocket (includes deductible)	$1,050	$1,050	$2,100	$2,100
Maximum Out of Pocket (includes deductible)	$5,250	None	$10,500	None
HSA Contribution Limits	Lesser of annual deductible or $2,700		Lesser of annual deductible or $5,450	
Office Visits and Prescription Drugs	Deductibles apply; no copays before full deductible reached (except preventive care)			
Preventive Medical Care and Preventive Prescription Drugs	Deductible does not have to apply			

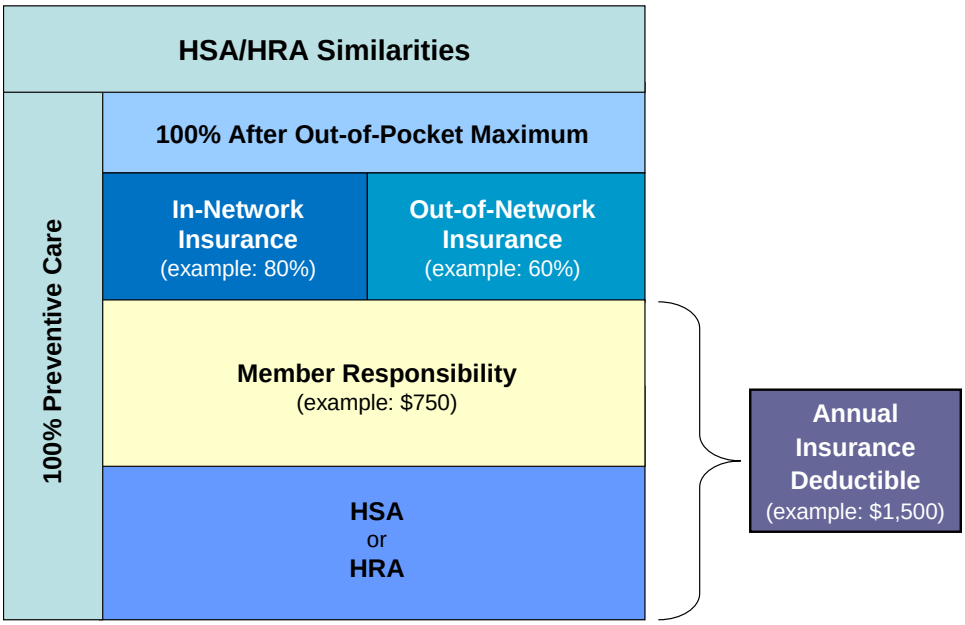
Individuals 55 or older can contribute up to an additional $700 in "catch-up" contributions for 2006; this will increase to $1,000 by 2009.

Eligible medical expenses include those under healthcare FSAs as outlined in IRS publication 502 (*www.irs.gov/pub/irs-pdf/p502.pdf*) and certain other insurance premiums, such as those paid for long-term care, while on unemployment/COBRA, and after age 65.

There is no requirement to be in an HDHP to spend money from an HSA. Although funds can be used for non-medical expenses, that distribution is taxed as ordinary income, with a 10% penalty if made before age 65.

HSAs and HRAs have similar characteristics and goals when viewed from a distance, but up close they're quite different:

After age 65 (or if disabled), non-medical distributions from HSAs are taxed as ordinary income with no penalty, creating what some see as a general purpose retirement savings vehicle.



The Kaiser Family Foundation's survey results (released in September 2005) indicated HRAs attract about 25% of members and HSAs about 15% of members.

HSA/HRA Differences		
	HSAs	**HRAs**
Eligibility	Individuals (employees) with high-deductible plan (HDHP)	Employees whose employers make available
Ownership	Employee-owned	Employer-owned
Health Insurance Requirement	Qualified HDHP required	None except by employer plan design
Contributions	Employer, employee, or both	Employer only
Annual Contribution Limits (2006)	For 2006, lesser of deductible: $1,050/$2,100 (single/family) minimum or IRS annual limit: $2,700/$5,450 Catch-up contributions of $700 age 55+ Maximum in-network out of pocket $5,250/$10,500	None legally required; employer sets contribution amounts
Funding	Account is fully funded, can be invested, and earns interest	Notional account or promise to pay; typically is not “credited” with interest
Fund Rollover	Allowed	Allowed; employer can establish limits
Portability	Fully portable; can take to new employer	Employer discretion (typically no); COBRA rights apply
Qualifying Expenses	Miscellaneous IRC 213(d) expenses; limited health premium reimbursements	Miscellaneous IRC 213(d) expenses; unlimited health premium reimbursements; employer determined
Nonqualified Withdrawals	Yes, but taxable, plus 10% penalty; no penalty after age 65, death, or disability	Not allowed
Combine With FSA	With restrictions	Order of fund use must be established by employer
Claim Substantiation	Not required	Required
Financial Partner	Required	Not required
Claim Processing	Debit card or automatic (best vendors)	Automatic (best vendors)

Significant entitlement, education, and transparency barriers often need to be overcome in providing HSAs. When this happens successfully, they offer substantial opportunities – encouraging members to partner with providers to get the best value/results and changing health insurance from its annual benefit cycle to a long-term program that:

- Inspires engagement in health
- Rewards thoughtful behavior
- Highlights the value of prevention
- Allows tax-advantaged savings for future health needs.

HSAs put more decision-making capability and responsibility in members' hands – a change that may not be embraced eagerly or quickly.

4

Marketplace Activity

The level of US marketplace activity around healthcare consumerism in HRAs and HSAs has been accelerating steadily.

The following table shows the growth of membership in these plans, by vendor, from 2004 to 2005. (As described in Section 2, MSAs and HRAs started in the late 1990s and early 2000s; HSAs emerged in 2004.)

While the account-based plans differ in some ways, the similarities make all experiences with health accounts relevant to any HSA evaluation.

Most every company that administers health benefits either has the ability to administer account-based plans or is developing an offering. However, there's a big difference between simply offering an HSA and being able to deliver a plan that succeeds for all stakeholders.

	Mid 2004	Mid 2005		
	Members	CDHP/HRA Members	HDHP/HSA Members	Total Members
Definity & UHC	320,000 + 100,000	688,000	345,000	1,033,000
Lumenos & WellPoint	165,000 + 25,000	400,000 (combined)		400,000
Aetna	191,000	340,000	50,000	390,000
CIGNA	6,000	125,000	75,000	200,000
BCBS of MN		51,000	50,000	101,000
First Health	96,000	96,000	N/A	96,000
PacifiCare	60,000+	84,800	6,500	91,300
Great West	46,000	73,600	9,500	83,100
Healthcare Service Corp.		45,000	35,000	80,000
Humana	14,000	67,000	0	67,000
Destiny Health	40,000	46,000	N/A	46,000
Principal Financial		16,500	16,000	32,500
Medica	1,775	5,000	18,000	23,000
Vested Health	7,500	14,000	N/A	14,000
Wausau Benefits		13,500	N/A	13,500
Mutual of Omaha	6,390	6,100	5,900	12,000
HealthPartners		3,800	6,200	10,000
Assurant	113,869			
UICI/HealthMarket	40,000			
Others (Blues, TPAs):	75,000+	500,000 (combined)		500,000
Totals	1,282,534+	2,300,000	1,050,000	3,300,000+

(Sources: 2005 Inside Consumer-Directed Care, Mercer)

Health Benefit Insurers/Administrators

As seen in the preceding table, a wide variety of vendors supports these plans; some of the better known pioneers include:

- Definity Health (purchased in 2004 by UnitedHealthcare)
- Lumenos (purchased in 2005 by WellPoint)
- UICI/HealthMarket
- Destiny Health.

Of the large traditional insurers, Aetna was the first to offer CDHPs to their own employees (January 2002) and still is a leader in the market. PacifiCare, BCBS of Minnesota, and CIGNA had early offerings with varying levels of success. Humana, while embracing the concept of consumerism in many ways, focused on building HRA-like products early on and was late to develop an HSA offering, which has hurt their market penetration in this arena.

HSA Trustees/Custodians

The majority of insurers and benefit administrators have partnered with financial institutions to act as HSA trustee or custodian. For instance, CIGNA and WellPoint have used JPMorgan Chase, while BCBS of Illinois and Lumenos have used Mellon Financial. At least 3 insurers (Principal Financial, UnitedHealthcare through their Exante Bank subsidiary, and Aetna through their financial arm) have formed their own HSA trustee capabilities.

In 2001, Booz-Allen Hamilton wrote an article – "The Next Trillion-Dollar Opportunity: Healthcare and Financial Services Convergence." In 2005, with HSAs and healthcare consumerism moving into the mainstream, this convergence seems inevitable. Yet in 2001, it took considerable vision to understand and identify the opportunity. Even at the end of 2003, when HSAs were enabled, many financial services firms had to start from a near standstill in developing their healthcare market strategy and products.

Today hundreds of banks, credit unions, and investment firms have HSA offerings:

- In 2005 some of the nation's largest banks, for example Citigroup and Bank of America, announced significant plans to enter the HSA marketplace
- Other major firms such as Wells Fargo, JPMorgan Chase, and Mellon Financial made substantial bids in 2004 to become dominant players in HSAs
- Niche players in the MSA market – like HSA Bank (formerly MSA Bank) and MSAver – began converting their MSAs to HSAs and gathering new accounts/assets.

The sophistication of HSA offerings has evolved rapidly. In 2004, almost no HSA trustees had created robust investment options. By late 2005, most of the leading HSA trustees had begun to allow some form of fund investment beyond earning basic money market or Certificate of Deposit-type interest. (A typical robust offering has 4-10 different mutual funds in different asset classes, and some options allow access to hundreds of funds[2].)

Financial services companies also are working hard to streamline account set-up processes, some even moving from requiring a mailed "wet signature" on an application to allowing e-signatures. These efficiencies are critical when dealing with healthcare enrollment, where members aren't accustomed to having to take action beyond choosing their benefits.

HSAs present a unique opportunity for the financial sector to participate more fully in healthcare – now one-seventh of the US economy.

Financial firms and insurers/administrators are striving to work together better – to learn each other's language and characteristics so they can deliver a more seamless, positive experience to members. Consider these differences:

- Financial firms are used to instant or daily transactions (such as ATM withdrawals and viewing account balances online), but healthcare and insurance firms typically reconcile transactions over weeks or months
- Healthcare and insurance companies deal with thousands of highly complex codes, procedures, and exceptions, but financial firms usually have a more limited set of transactions.

Both industries are making efforts, but the process of learning to work together well on behalf of consumers may take years.

An August 2005 survey of 24 HSA trustees by Inside Consumer-Directed Care indicated they had opened nearly 530,000 HSAs with $565 million in assets[3].

It's not surprising that the financial services sector is so interested in healthcare dollars. The Washington DC-based HSA Coalition created a model to estimate the accumulated funds in HSAs over time, based on market penetration. The grid below shows that even with modest HSA adoption, assets quickly move toward and beyond $100 billion.

Potential Cumulative HSA Deposits Based on Market Penetration										
HSA Market Penetration	2005 (in billions)		2006 (in billions)		2007 (in billions)		2008 (in billions)		2009 (in billions)	
	Low	High	Low	High	Low	High	Low	High	Low	High
0.2%	0.42	0.84	4.83	9.66	15.44	30.87	29.14	58.28	37.54	75.08
2.0%	4.20	8.40	10.50	21.00	21.00	42.00	30.45	60.90	44.10	88.20
5.0%	10.50	21.00	19.95	39.90	33.60	67.20	41.48	82.95	56.70	113.40
10.0%	21.00	42.00	35.70	71.40	54.60	109.20	59.85	119.70	77.70	155.40
15.0%	31.50	63.00	51.54	102.90	75.60	151.20	78.23	156.45	98.70	197.40
20.0%	42.00	84.00	67.20	134.40	96.60	193.20	99.88	206.50	119.70	239.40
25.0%	52.50	105.00	82.95	165.90	117.60	235.20	114.98	229.95	140.70	281.40

(Sources: September 2005 Inside Consumer-Directed Care, HSA Coalition)

Private Sector

Private sector and individual enrollment has driven the growth of these plans to date.

The private sector employers offering HSAs/HRAs are too numerous to list, but include many of the nation's most recognizable companies, such as:

- Amazon.com
- Coors
- Fannie Mae
- Fujitsu
- Kraft
- Kroger
- Levi Strauss
- Northrop Grumman
- Safeway
- Staples
- Starwood Hotels
- Toys "R" Us
- Wells Fargo
- Whirlpool.

Some companies have made these plans the only health benefit option for all or a significant portion of employees, including:

- 7-Eleven
- CIGNA
- Coca-Cola Bottlers
- ConAgra
- Sara Lee
- Schneider Trucking
- Textron
- UnitedHealthcare
- Wendy's
- Whole Foods.

Public Sector

Federal programs have seen low enrollment in these plans so far:

- The Federal Employees Health Benefits Program – covering 9 million workers, retirees, and their families – adopted account-based health plans early on. In January 2003 the American Postal Workers Union, which manages plan options for several hundred thousand federal workers, began offering an HRA from a leading CDHP vendor (Definity) but enrolled fewer than 5,000 members.

- This experience – similar to that of other public sector plan sponsors – demonstrates the need to communicate and market the plan to the eligible population. (To be fair, there are other barriers to change in the federal employee system; the FEHBP has nearly 300 plan options (279 for 2006), and typically only about 5% of the population changes health plans in any given year.)

- Despite its slow start, the FEHBP expanded these options (Aetna began offering HRAs in 2004) and the APWU's HRA grew to 20,000+ in 2005. Although the FEHBP had 18 HSA-compatible plans in 2005, they followed the same pattern as the HRA offerings, attracting only about 5,000 members. All told, Inside Consumer-Directed Care reported only 33,000 members in FEHBP account-based plans for 2005.

- The number of HSA-based options and markets should expand considerably in 2006. Aetna's HSA alone will double – from 45 markets serving 56% of the population to 91 markets serving 72% of the population. However, given the number of competing options, the population's lack of plan-switching tendencies, and no means to deliver an effective education campaign, FEHBP's 2006 HSA enrollment is likely to remain low.

State employee programs haven't fared much better at building acceptance and attracting enrollment in account-based options:

- In 2004, Georgia piloted HRAs with 3 sub-groups, all under 10,000 employees, using 3 separate vendors; 2 groups had about 5% enrollment and 1 group had about 1% enrollment. For 2006, Georgia will offer an HSA-compatible HDHP without sponsoring or contributing to an HSA.

- Arkansas also was on the vanguard of HSA-compatible HDHPs, with an offering in place for January 2005. Although a trustee was defined and payroll contributions to the HSA were enabled, state contributions were not made. Members were told they must make "mandatory" contributions of $20 a month if they wanted to enroll in the plan. In addition, the HSA option was competing with 8 others (2 PPOs, 3 POSs, and 3 HMOs). Of 75,000 eligible state workers and teachers, fewer than 200 enrolled in the new plan. The program expects to more than double participation in 2006, but the offering is still not to a level where it will have any measurable impact on total cost, utilization, quality, or behavior.

- Indiana is offering an HSA in 2006 among the 5 options for its 33,000 employees (administered by Anthem BCBS of Indiana). Employees electing individual coverage will have a $2,500 deductible; those electing family coverage will have a $5,000 deductible. The state will deposit $1,500 in individual HSAs and $3,000 in family HSAs as well as pay the entire premium. State officials are expecting 5%-10% of the employee population to choose the HSA[4].

- Florida takes a big step toward consumerism and account-based plans in 2006 by offering a traditional PPO and HMO plus an HSA-compatible PPO and HMO. The state will sponsor an HSA trustee and contribute to the HSA for those who enroll: $500 for single members and $1,000 for families. Florida also is making meaningful efforts to communicate the new options, conducting many meetings and providing resources on *www.myflorida.com*. However, as evidenced by actual enrollment to date being less than expected (1%), significant membership is still hampered by many of the same challenges other large public sector plans have faced. These obstacles include a dispersed workforce who may not even consider changing plans each year and some workers paying no contributions for health benefits (they won't see the value in moving to an HSA). Regardless of first-year enrollment, Florida is building a foundation for greater impact of their HSA plans going forward.

  Offering 2 HSAs demonstrates commitment, which should boost enrollment.

County and city governments have adopted HRAs and HSAs as well:

- Broward County in Florida added an HRA for January 2004

- The City of Provo, Utah added an HRA in 2003 and now offers only account-based health plans (full replacement)

- Utah County, Utah offers only HSA-based plans for 2006

- The City of Las Vegas adopted HRAs in 2004 and saw over 60% of their workforce choose these plans

- The City of Hurricane, West Virginia's HRAs (started in 2003) reported cumulative savings of nearly an entire year's worth of healthcare costs over 2 years.

Universities and schools also are actively evaluating and adopting these plans:

- The University of Minnesota was one of the first to put in an HRA in January 2002, followed by Louisiana State University later that year

- The University of Kentucky and the University of California (certain schools) followed in 2003 and 2004

- Stanford University, Finch University/Chicago Medical School, Yale, DePaul, and many others have since offered account-based health plans.

A number of public school districts are adopting HSAs and HRAs, too:

- The Cajon Valley Union School District in California replaced their PPO with an HRA in January 2004 and attracted nearly half its members into the new plan
- Houston's Independent School District and many aligned school districts in the region also adopted HRAs in 2004.

Many large and small public sector entities are evaluating their HSA options as well:

- The Texas Employees Retirement System was recently authorized by House Bill 2772 to evaluate the long-term effects of such a plan
- Even some state Medicaid programs, such as South Carolina's, are considering how account-based plans might be leveraged to create a more financially sustainable health safety net for the disadvantaged.

* * * * *

The next section uses research and experiences with these plans to help guide the PEBB in avoiding pitfalls and achieving success.

5

Early Evidence of Impact

Every new idea or direction in healthcare and benefits comes with the potential for unintended consequences. Those critical of healthcare consumerism and account-based plans have raised valid questions about:

- Continued utilization of needed services
- Risk segmentation and adverse selection
- Equity for those with chronic conditions and lower incomes.

Answering Questions, Addressing Challenges

A growing body of experience-based information is answering the questions and building solid first-generation strategies to address the challenges.

- *Many analysts point to the potential for underutilization, as members avoid preventive care to preserve funds in their account.* Harris Interactive Inc.'s survey found:
  - 33% of people in HDHPs (not necessarily with an account) had a specific medical problem but did not visit a doctor, compared to 17% of those in traditional plans.
  - 29% of HDHP participants took a medication less often than they should have and 28% did not fill a prescription, compared to 14% and 15% of those in traditional plans, respectively[5].

  To avoid these situations, many account-based plans provide 100% coverage for preventive services outside the deductible, so members have no financial reason not to seek recommended preventive care.

HSA legislation and guidance allow preventive medications to be covered without being subject to the deductible, reducing the concern that people will be reluctant to pay for needed prescriptions. In the second half of 2005, health plans (including Aetna, UnitedHealthcare, and several Blues plans) as well as pharmacy benefit managers (such as Medco, Caremark, and Express Scripts) built products to address this issue.

- *When offering a CDHP alongside a traditional plan, the risk pool can become segmented if disproportionate numbers of healthy members migrate to the CDHP*.

  Removing these employees from the traditional plan's risk pool adversely affects experience, which can result in continuously larger cost increases to administer the traditional plan – until it becomes unaffordable. (See page 30 for more on adverse selection.)

  Mercer experience indicates the demographics of employers adopting CDHPs often is very similar to the general population in terms of gender, age, and family status. However, selection based on health status and prior health use is common and must be accounted for in benefit design and pricing. For example, 2 employers, each with about 6,500 mostly white collar employees and similar average 2003 healthcare costs, offered these plans in 2004:

  – The first employer's CDHP plan design was less attractive to employees who were high users of healthcare and attracted roughly 10% of the population. The 2003 average claim cost of member employees in the 2004 CDHP was $2,591 – much lower than the all-employee average of $6,226. Healthcare usage was only 42% of average in the CDHP group, signifying considerable selection based on health status and usage.

  – The other employer designed and positioned the CDHP to be attractive to a broader base and attracted 34% of employees. The 2003 average claim cost of member employees in the 2004 CDHP was $5,915 – very close to the all-employee average of $6,320. Healthcare usage was 94% of average in this CDHP group, signifying very little selection based on health status and usage.

  Plan sponsors can design and position a CDHP to reduce selection, but typically the lower enrollment in the CDHP option, the greater the selection based on health status and usage.

	Employer 1	Employer 2
Percent 2004 HRA Enrollment	10%	34%
Average Claim Cost of 2004 HRA Members in 2003	$2,591	$5,915
Average Claim Cost of All Employees in 2003	$6,226	$6,320
Percent of Average Prior-Year Cost	42%	94%
Amount of Health-Based Selection	Significant	Negligible

- *To alleviate the concern that people with chronic conditions or lower income will be disadvantaged, plans are designed with special incentives and protections.*

  For instance, some CDHPs recognize that members with chronic illnesses may have more cost sharing. To offset part of that added cost, the plan sponsor contributes extra funds to the account. In addition, the premium can be lower for members with a chronic illness who complete a disease management or other risk reduction program.

  – As a general rule, 80% of claim costs are driven by the 20% of employees with chronic and acute illnesses. Structuring the plan to make it attractive for employees who drive 80% of costs reduces risk segmentation, targets the highest cost drivers, and engages these members.

  – A 12-month Aetna study (released June 2004) on 13,500 participants in their HealthFund HRA indicated members with diabetes not only were not avoiding care, but were actually increasing the amount of certain appropriate care received. This analysis was based on the standard Health Plan Employer Data and Information Set (HEDIS) measures for diabetic care shown below:

Care management and wellness incentives, such as for participating in health risk assessments, are important features in account-based plans.

Diabetic Tests	Change in Number of Tests
Glycated Hemoglobin	Positive Change
Lipid Screening	No Significant Change
Micro Albumin	Positive Change
Retinal Eye Exams	No Significant Change

Salary-based contributions and designs are being adopted. One plan sponsor recognized a larger deductible for lower-paid workers was more meaningful than for those with average/above-average salaries. They designed a program that divided members into 4 salary ranges and adjusted the deductible accordingly – matching lower pay with lower deductible risk. Another plan significantly reduced premiums for members earning less than the living wage in their area.

Account-based plans are designed to encourage consumerism and wise choices in *non-emergency* situations. These plans do not anticipate that members will be engaged consumers or change purchasing behaviors in dire situations (although having a concerned relative or friend who's a savvy healthcare consumer can mean more proactive coordination of care and better outcomes).

Account-Based Health Plan Studies

Specific HSA and other account-based health plan research continues to expand:

- An enrollment study by Milwaukee-based Assurant (formerly Fortis Health – a major provider of individual HSA-based coverage with 100,000+ members in 2005) found 57% of their HSA policyholders were over age 40, and 73% were families with children[6]. These results indicate older employees are not averse to account-based plans and that they can be popular among employees with families.

- A study by America's Health Insurance Plans found 37% of those purchasing HSAs were previously uninsured, demonstrating the capacity of account-based strategies to expand coverage access[7]. A study by eHealthInsurance (the country's largest on-line health insurance broker) found most people with HSAs opt for more comprehensive plans that generously cover hospitalization, doctor visits, lab tests, emergency room care, and prescription drugs after the deductible[8]. eHealthInsurance also found more than 40% of HSA purchasers in the individual market earned less than $50,000 annually and 45% were 40 or older[9].

  At least in the individual market, HSAs are not necessarily just for the young and wealthy.

- In 2004, Mercer asked 84 plan sponsors to rank the objectives of their account-based plans. Promoting healthcare consumerism was ranked as the most important, by 80% of study participants.[10] Lowering the organization's benefit costs, noted by 69% of respondents, was the second most important objective. Asked if their most important objectives had been met, 53% agreed or strongly agreed and 28% indicated it was too soon to tell; 13% were neutral and 5% disagreed.

- The same Mercer study asked plan sponsors to characterize the reaction of their workforce to account-based coverage. More than half, 63%, had a strongly positive (13%) or more positive than negative (50%) response. Just 30% reported an evenly mixed positive and negative response; only 8% reported a response more negative than positive (7%) or strongly negative (>1%).

Other Consumerism and CDHP Studies

- The recent EBRI/Commonwealth Fund Consumerism in Healthcare Survey examined numerous issues surrounding consumerism[11]. Overall, study participants were less satisfied with CDHPs, but were more engaged consumers than people in traditional plans. Over 70% of respondents in CDHPs strongly or somewhat agreed their health plan made them consider cost when deciding to fill a prescription or see a doctor; less than 40% of people in traditional plans considered cost. However, 40% of people in CDHPs said they avoided getting healthcare due to cost, compared to only 17% of those in a traditional plan. CDHP members were more likely to ask their doctor to prescribe a less expensive drug (44%) than people in traditional plans (27%). Also, 63% of those in traditional plans rated their overall satisfaction with the plan as extremely or very satisfied, while only 42% of CDHP members felt this way.

- One of the most extensive evaluations to date was McKinsey & Company's 2005 study of the health insurance arrangements of more than 2,500 Americans[12], which found account-based plan members to be:

  – 50% more likely to ask about the cost of a procedure

  – 33% more likely to independently identify treatment options

  – 300% more likely to choose a less extensive and expensive treatment option

  – 25% more likely to have healthy behaviors

  – 20% more likely to follow recommended protocols for chronic conditions

  – 200% more likely to discuss prescription drug costs and options with their physician.

  In addition:

  – Only 44% were as satisfied with the CDHP as they were with their prior plan

  – 80% indicated they had insufficient information on provider costs.

For CDHPs, McKinsey eliminated plan selection bias by including only members whose employers had full replacement (offered only account-based health plans).

- A 2004 Segal study of 27 employers with 650,000 total employees found most CDHP plan sponsors see desired cost and utilization changes[13]. The study reported:

  – 50% of respondents experienced a decrease in medical trend and only 8% reported an increase

  – 54% experienced a decrease in prescription drug costs and only 17% experienced an increase

  – 46% experienced a decrease in the number of emergency room visits and none experienced an increase

  – 29% had fewer physician office visits and only 8% had more.

- In June 2001, Humana commissioned a mail survey of their 4,680 corporate office employees to assess the initial impact of offering a CDHP option. The results concluded:

  – Employees were 3 times more likely to select the CDHP option if they had not visited a medical provider during the 4 weeks before enrollment.[14] This indicates healthier risks gravitated toward the CDHP, potentially compromising the traditional plan risk pool's integrity.

  Note these survey results are limited to the early experiences of a single employer offering a restrictive CDHP with limited support tools.

  – Of the sociodemographic breakdown (race, sex, age, education level), those selecting the CDHP option were more likely to be male, white, hold a college degree, and not have a chronic illness.[15]

More Plan Sponsor and Vendor Experiences

- A company with about 7,000 employees who implemented an HRA had Mercer evaluate the utilization and costs of approximately 10% of members – both before and after they were enrolled.

  This company's HRA enrollees increased preventive care and generic prescription use while decreasing utilization and costs.

	PPO 2003	HRA 2004
Employee Enrollment	667	667
Adult Preventive Exams/1,000 EEs	319.3	403.3
PCP Office Visits/EE	3.4	3.4
ER Visits/1,000 EEs	197.9	79.5
Inpatient Claims/EE	$518	$333
Inpatient Admissions	46	15
Inpatient Average Length of Stay	3.43	2.93
Prescription Claims Paid PEPM	$40	$25
Total # Prescriptions PEPM	0.97	0.43
% of Generic Prescriptions	37%	43%
Total Claims Paid (Medical + Prescription) PEPM	$213	$173

- Mercer recently analyzed the benefit program of another large employer with over 20,000 employees who has been offering HRAs as the only option (full replacement) for 3 years. The analysis found:

  – Year-over-year costs were down 7.5% per capita with a 3.1% underlying trend (the cost increase after throwing out random and plan design effects)

  – Utilization dropped 1.9% against last year's actual and 5% against expected

– Benefits were $5.5 million below what they were last year and $13.2 million below what an average large company was expected to experience for the first half of the year

– The employer's cost share decreased from 90% to 82% (excluding contributions), while maintaining benefit competitiveness.

These results indicate that after 3 years with only HRAs, the program was successful at controlling trend, utilization, and costs.

- A 2004/2005 Mercer meta-study on effectiveness of account-based CDHPs yielded the following preliminary grid[16,17,18], providing evidence that these plans are generally having the desired impact on claim costs, utilization, and healthcare behavior.

	Vendors				Individual Employers			
					Full Replacement Offerings			66% Enrollment
	Aetna (Health-Fund)	United (iPlan)	Definity (Definity Plan)	BCBS MN (Options Blue)	St. Luke's (Health-MAP)	Whole Foods	Textron	Serigraph
	(based on 13,800 members)	(based on 20,000 members)	(based on 320,000 members)	(based on 12,000 members)	(based on 1,500 employees)	(based on 15,000 employees)	(based on 25,000 employees)	(based on 1,000 employees)
Financial								
Claim Cost					↓ 12.7%	↓ 13%		
Primary Care Cost	↓ 11%							
Prescription Drug Cost	↓ 5.5%				↓ 20.4%			
Total Cost	↓ 6.3% (from trend)	↑ only 1%	↑ only 3.2%		↓ 20%	↓ 13.9% (from trend)		↓ 1% over 1½ yrs
Utilization								
Claims		↓		↓ 7%	↓ 11.3%		↓ 13%	
Primary Care	↓ 10.9%				↓ 3.6%			
Preventive Care	↑ 23%*	↑		↑				
Admissions	↓ 5.2%		↓ 26% (from trend)			↓ 22%		
ER Visits	↓ 3%	↓		↓ 10%	↓ 4.4%			
Specialist Visits	↑ 3%*	↓						
Prescription Drugs	↓ 13%							
Re-enrollment/ Member Satisfaction	90%	90%	95%			95%		

* There was only an 8% increase in preventive care and a 7% increase in specialist visits for a similar population in a traditional managed care plan.

Most plan sponsors have opted to introduce healthcare consumerism and account-based plans incrementally – offering these options alongside traditional plans in the first few years – often with a long-term strategy to have only account-based plans.

Success Factors

In summarizing this research, these elements of CDHP success continue to surface:

- Ensuring adequate funding by the employer for the account
- Providing significant, sustained member communication and education
- Building in financial and other incentives to encourage smart healthcare consumerism
- Making the account a key element of the plan sponsor's benefit strategy
- Breaking the inertia that leads members to continue with past plans and behaviors through significant changes to the existing program
- Choosing the right vendor partner.

These success factors all encourage enrollment in the CDHP.

6

HSAs and PEBB

Although the experiences of employers that have offered account-based health plans are useful and instructive, each benefit environment differs – every population's demographics, benefit designs, utilization patterns, health conditions, provider access, quality, and pricing will affect results. Therefore, to understand the impact of HSAs in the PEBB, the State of Washington's unique benefit profile must be considered.

Structuring the Program

Several preliminary assumptions have been used to model and anticipate the financial implications of introducing an HSA into the PEBB landscape. While these assumptions are a reasonable place to begin, many would need fine-tuning for final program design.

In some account-based programs, multiple design options would be HSA-compatible; for this analysis we've assumed there will be only 1 HSA plan.

HSA design requirements from the federal government change each year (indexed based on the CPI). For purposes of the following illustration, we used a basic HSA-compliant HDHP. This sample design is expected to be compliant through 2008, based on a 2.5% annual CPI increase, with a deductible at the lower range of HSA compliance.

In general – when considering the sample plan design's deductible with the State-funded HSA – this design is reasonably close to existing PEBB PPO (Uniform Medical Plan) benefits. (This includes which providers are in and out of network as well as what care is covered.) Yet it has consumerism design elements such as coinsurance being favored over copays.

Sample Plan Design (HDHP)		
	Network	**Out-of-Network**
State-Funded Health Savings Account Contributions		
Individual	$500	
Family	$1,000	
Annual Deductible		
Individual	$1,100	$2,200
Family	$2,200	$4,400
Coinsurance	80%	60%
Coinsurance Maximum (excluding deductible)		
Individual	$1,500	$3,000
Family	$3,000	$6,000
Preventive Care	100% to $500/member	Not covered
Prescription Drugs	Deductible, then 20%	
Generic	$10 minimum, $100 maximum	
Preferred Brand	$25 minimum, $100 maximum	
Non-Preferred Brand	$40 minimum, $100 maximum	

Another crucial element in structuring the program is whether other traditional health plans would be offered with the HSA option. This decision significantly affects the financial implications of an HSA in the PEBB environment. For purposes of the following estimates, the HSA is shown as an option alongside other health plans, where the HSA attracts 2%-10% of enrollment.

While lower enrollments are a realistic expectation in the earlier HSA years if existing programs remain unchanged, longer-term cost savings and quality improvement opportunities are likely attainable only with higher enrollment.

Attracting 10% of enrollment would, at a minimum, require:

- Significant efforts to communicate with and educate members on benefit options
- Active enrollment (members can't ignore enrollment and automatically receive the benefits they had in the prior year)
- Additional care management and wellness program participation incentives.

Enrollment below 10% would have smaller overall financial, behavior change, and health improvement impact.

Financial Implications

Estimated savings for introducing an HSA into the PEBB environment are based on these assumptions:

- Projected 2007 aggregate claims and administrative health costs of $1.131 billion for 127,700 active and pre-65 retired employees
- Level membership in PEBB and total cost continuing to be shared at current levels between members and the State (that is, any contributions, from pay or otherwise, will not vary from current percents); however, contributions by plan can differ to encourage HSA participation, while keeping the total amount of contributions constant
- The State paying for a trustee's ongoing account maintenance at $3 per employee per month, with members responsible for other charges (such as reprinting checks or any ATM fees).

The benefit redesign changes point-of-service cost-sharing requirements from the current offerings to an HSA-compliant HDHP. The graph on the next page shows the impact of 2%, 5%, and 10% enrollment.

A decrease in aggregate spending would accompany increased consumerism:

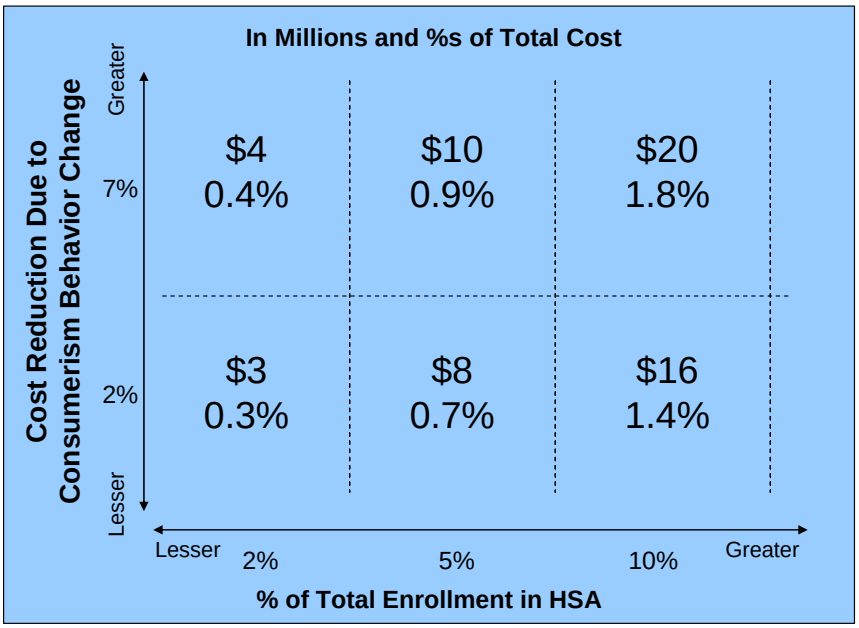
- Lower utilization of inappropriate or unnecessary medical services and prescription drugs
- Demand shifting away from more invasive higher-cost treatments and therapies
- A combination of member and provider attention on cost and quality of services, with increased desire to provide and receive high-value medical care
- Heightened member awareness of how their health status and behaviors affect not only their physical but financial well-being – leading to better long-term lifestyle and purchasing decisions.

The successful move to an HSA often hinges on plan sponsor funding of the account. Without State support of the HSA, an undue burden could be placed on members with additional cost sharing at the point of service. In addition, without an account, it could be argued that the HSA is only raising deductibles and passing costs on to members.

The consumerism effect is shown at 2 assumption levels: a low of 2% cost reduction and a high of 7% cost reduction.

The sample plan design shown on page 28 assumes a direct annual HSA contribution by the State of $500 for single members and $1,000 for those covering their family. This contribution level will encourage HSA enrollment while giving members more accountability for how they spend healthcare dollars.

Direct contributions by the State into an HSA would require virtually all members in the plan to open a financial account.



The graph above demonstrates the potential range of savings – $3 million (0.3% of total cost) to $20 million (1.8% of total cost) – from introducing an HSA option with modest enrollment, limited changes to the existing program, and the State funding the HSA as well as paying for account administration.

Additional Considerations

A fundamental goal of consumerism and account-based plans is to accelerate reengineered delivery of health services for more efficient, higher-quality, lower-cost care.

Projecting costs always involves some uncertainty – several variables merit mention:

- *The multi-year nature of account-based health plans and consumerism*. The estimated numbers above are a potential 1-year snapshot of the change in aggregate costs, yet an HSA also gives members the opportunity to build up tax-free savings toward future health expenses. Many analysts believe these efforts will lower future trend of health cost increases, too. More comprehensive and detailed financial modeling done over time may show the savings will grow from adding HSAs to the PEBB.

- *Impact of adverse selection*. In any plan that allows choice, members pick the option that will best meet their needs, based on anticipated utilization and health status in the upcoming year. The implication is that if all healthy members take one plan and all sick members another, the plan caring for the sick will bear an undue cost share and become too expensive to maintain. PEBB curtails adverse selection now by using normalized premiums (non-risk-adjusted premiums that assume each plan enrolls the entire PEBB population) to set employee contributions.

There is evidence that when an account-based plan is offered alongside a traditional plan with richer benefits (such as a lower deductible), members who anticipate fewer health needs will enroll in the account-based plan. The extent of selection based on prior health use and health status can vary significantly – from no selection to members in an account-based plan having prior year health expenses of 50% or less than other members. As enrollment in an account-based plan grows, selection of healthy members tends to decline. Selection also tends to decline in account-based plans over the years they're offered.

- *Legal issues*. Implementing the HSA design described here may require amending several laws – either to allow certain provisions or to optimize anticipated advantages through the State's contribution. (Mercer does not practice law; we conducted this analysis in the course of our consulting practice. Formal legal opinion from the State attorney general's office and perhaps others will be required before pursuing an HSA.)

State contributions to HSAs for select groups and not others may need interpretation, with further legal implications for collective bargaining.

- *Effect of changing members' premium contribution*. Plan sponsors often reduce member costs to participate in a health plan when benefit levels are changed from generous HMO/PPO designs to HDHP designs with greater point-of-service cost sharing. While it's not a requirement, the State may want to consider this; however, a good portion of the benefit design reduction is already offset by the assumed State contribution to the HSA.

- *State investment in communication and education efforts to support HSAs*. Results for the State would benefit from significant communication and education – starting well before members have a choice between plans or are enrolled in an HSA. Ongoing resources will be necessary to support the new skills required to manage health, treatment choices, and the HSA option properly. Bringing the healthcare provider community up to speed on HSAs, benefit changes, and the expanded focus on value and quality also would be advantageous. A reasonable minimum investment by the State for these efforts would be $1 million.

Although vendor partners sometimes offer these services, supplemental State efforts will be needed to maximize results.

Vendor Partners and Successful Delivery

Selecting the proper partner to deliver HSAs to the PEBB population will be a major success factor. A strong vendor partner with a user-friendly solution as well as proven communication and education capabilities can:

- Increase HSA enrollment

- Enhance ability to keep members engaged in improving health and related decisions.

There is much variability in the quality of current HSA program vendor partners for PEBB. We expect significant improvements in capabilities over the next 3 years. Consider, for example, the 2 distinct components to an HSA: the financial account itself and the HDHP insurance that enables the account. Vendors are building links between these components so plan sponsors and members don't have to manage and coordinate them. Better solutions might include a single dedicated customer service line for any account *or* insurance issue.

Choice within the PEBB program is important to member satisfaction, yet any move toward consumerism and HSAs at the State will likely be gradual, measured, and deliberate.

Enrollment Is the Key

As underscored by this analysis, HSA enrollment will play a large role in financial and other implications, but without substantial changes to the existing program, initial enrollment is likely to be modest; the graphic below shows key elements:

	High Enrollment
Breaking "inertia" of traditional plans	✓
Active enrollment (vs. passive)	✓
State funding for the HSA	✓
Endorsement and support	✓
Effective communication and education strategy	✓
Lower member contributions than for other plans	✓

In addition, HSAs may be more valuable to specific populations:

- Early retirees now pay 100% of premiums, so any reduction in premium with an HSA may have greater impact for this group, resulting in higher enrollment
- Those 55 and older can contribute tax-advantaged "catch-up contributions" to the HSA ($700 in 2006, $800 in 2007, increasing to $1,000 by 2009) – an attractive feature for this group
- Other PEBB population segments may like the ability to save tax-advantaged dollars in the HSA for healthcare needs in retirement.

Conclusion

While some uncertainty surrounds the long-term implications of introducing an HSA to the PEBB environment, there is evidence for meaningful cost savings and quality improvement to the program over time.

* * * * *

Although HSAs are an important and visible element, they are only one of many avenues PEBB can pursue to encourage greater healthcare consumerism; other elements include:

- Structuring care management and wellness programs to engage members in their health
- Providing accessible, user-friendly tools, information, and support to assist in member decisions
- Building a platform of data to identify efficient healthcare providers as well as effective treatment options.

These types of consumerism efforts are important to members regardless of benefit designs, and are likely to reach fuller potential within aligned plans, like HSAs, that motivate healthcare involvement.

MERCER
Health & Benefits

Mercer Health & Benefits LLC
One Union Square
600 University Street, Suite 3200
Seattle, WA 98101
206 808 8800

[1] Inside Consumer-Directed Care, *Legislators in Most States Have Cleared Path for HSAs, But Some Hurdles Remain*, Volume 3; Number 16 (August 19, 2005).

[2] Amy Turkington, Press Release, *CIGNA Healthcare Adds Investment Options to Health Savings Accounts*, CIGNA Healthcare (June 14, 2005).

[3] Inside Consumer-Directed Care, *Assets of HSAs Hit $565 Million*, Volume 3; Number 18 (August 23, 2005).

[4] Tom Murphy, Indianapolis Business Journal, *State Revamps Health Coverage*, Volume 26; Issue 34 (October 31, 2005).

[5] Karen Davis, President, The Commonwealth Fund, Address to the National Academy of Social Insurance, *High Deductible Health Plans and Health Savings Accounts: For Better or Worse*? (January 27, 2005) (source data: Harris Interactive Inc.).

[6] Gracie-Marie Turner, *California Dreamin*, Health Policy Matters (August 5, 2005).

[7] Larry Akey, Press Release, *HSAs More Than Double in Six Months, New AHIP Study Shows: Lower Premium Health Insurance Plans Attract Employers, Uninsured and Older Purchasers,* AHIP (May 4, 2005).

[8] eHealthInsurance, Press Release, *Health Savings Accounts: The First Year in Review* (February 15, 2005).

[9] Same as above.

[10] Mercer Human Resource Consulting, N*ational Survey of Employer-Sponsored Health Plans: 2005 Survey Report*.

[11] Paul Fronstin and Sarah Collins, *Early Experience With High-Deductible and Consumer-Driven Health Plans: Findings From the EBRI/Commonwealth Fund Consumerism in Healthcare Survey*, EBRI Issue Brief No. 288 (December 2005).

[12] Vishal Agrawal, et al., Press Release, *Consumer-Directed Health Plan Report – Early Evidence Is Promising* (insights from primary consumer research provided by McKinsey & Company) (June 2005).

[13] The Segal Company's 2004 Survey of Consumer-Driven Health Plans (Spring 2005).

[14] Fowles, et al., *Early Experience With Employee Choice of Consumer-Directed Health Plans and Satisfaction With Enrollment*, HSR: Health Services Research 39:4, Part II (August 2004).

[15] Same as above.

[16] Ron Lieber, *Whole Foods Plan Tries to Give Workers a Reason to Save*, The Wall Street Journal (June 23, 2004).

[17] Inside Consumer-Directed Care, *Positive Results Put Insurers Behind CDH, but Results Are Nothing New, Vendor Says* (July 9, 2004).

[18] Inside Consumer-Directed Care, *Hospital's Full-Replacement Plan Cuts Medical, Rx Costs in First Year* (June 4, 2004).